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BEFORE THE HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

"Innovative Solutions to Medical Liability"

JULY 13, 2006

Mr. Chairman, members of the Committee, I am Joanne Doroshow, President and Executive Director of the Center for Justice & Democracy, a national public interest organization that is dedicated to educating the public about the importance of the civil justice system.

In addition to our normal work, CJ&D has two projects: Americans for Insurance Reform, a coalition of over 100 public interest groups from around the country that seeks better regulation of the insurance industry; and the Civil Justice Resource Group, a group of 24 prominent scholars from 14 states formed to respond to the widespread disinformation campaign by critics of the civil justice system.

I appreciate the opportunity to address the issue of medical malpractice litigation and patient safety. Today, I would like to discuss why mandatory alternatives to medical malpractice litigation would not only have terrible consequences for patients, but also hurt patient safety.

INTRODUCTION AND SUMMARY

CJ&D and the malpractice victims with whom we work all agree that alternative systems, where both parties voluntarily agree to take a case out of the civil justice system, are not only appropriate, but currently resolve the vast majority of legitimate medical malpractice claims today. Most victims with whom we work resolved their cases through informal pre-trial settlements. This is consistent with findings published in the May 11, 2006 *New England Journal of Medicine,* that only 15 percent of claims are resolved by jury verdict today.[1]

There is nothing wrong with alternative dispute resolution (ADR) or alternative compensation systems, provided they are truly voluntary and do not eliminate the right to trial by jury. This view is consistent with a July 27, 1998 report released jointly by the American Medical

Association, the American Bar Association and the American Arbitration Association, entitled *Health Care Due Process Protocol*, which found that, "[t]he agreement to use ADR should be knowing and voluntary. Consent to use an ADR process should not be a requirement for receiving emergency care or treatment. In disputes involving patients, binding forms of dispute resolution should be used only where the parties agree to do so after a dispute arises."

However, we and the medical malpractice victims with whom we work strongly object to schemes that *require* that cases be heard in informal settings, such as Health Courts, without the option of having either juries or unbiased judges making decisions, and with schedules of benefits that deny individual justice. Such systems tilt the legal playing field heavily in favor of insurance companies that represent health care providers. This is especially so in systems where the burden of proof on patients (as is contemplated by so-called Health Courts) is little different than would be required in a court of law.

What's more, removing the possibility of jury trial will infect the bilateral bargaining/settlement process, through which most legitimate medical malpractice disputes are resolved. Ordinarily, the victim's warning that he or she is prepared to take a case before a jury helps to ensure a fairer settlement. Without the prospect of a jury trial, the health care/insurance company's leverage in any settlement negotiation is greatly increased, to the detriment of innocent patients.

Moreover, it is bad enough that the law contemplates a one-size-fits-all schedule of benefits that, like caps, take into account no individual circumstances of a person's life. But also, political bodies will set these compensation judgments, and insurance and health industry representatives can lobby these bodies. It is the lesson of history that, unlike our courts and juries, political money and lobbying can easily influence legislatures and agencies that retain the sole power to redefine limits and benefits under codified compensation systems. Once political forces take over a statutory system, as they always do, it is merely a matter of time before even the most pro-victim proposal is turned into a nightmare for the injured person.

Removing the threat of litigation would also disrupt other critical functions of the legal system, most importantly the deterrence of unsafe practices, especially in hospitals as explained below. Clearly, we need to look for ways to improve the quality of health care services in our country and to reduce preventable medical errors. Alternatives to litigation will not only fail to fully compensate patients, but they will also undermine restraints the civil justice system currently imposes on dangerous conduct.

Patient safety should be our first priority. There are many productive areas to focus upon – weeding out the small number of doctors responsible for most malpractice, improving nurse staffing ratios, to mention just two. Mechanisms that shield grossly negligent doctors from accountability by intruding upon the legal system are simply the wrong way to go.

WHERE'S THE CRISIS?

On May 11, 2006, two articles published in the *New England Journal of Medicine* lead to the conclusion that despite a tremendous amount of negative rhetoric about medical malpractice litigation, the medical malpractice system works pretty well.

In their closed claims study, Michelle Mello, David M. Studdert and others found that despite its costs, the current system works: legitimate claims are being paid, non-legitimate claims are generally *not* being paid, and that "portraits of a malpractice system that is stricken with frivolous litigation are overblown."[2] The authors found:

- Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.
- Eighty percent of claims involved injuries that caused significant or major disability or death.
- "The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers."
- **"**Disputing and paying for errors account for the lion's share of malpractice costs."
- **"**Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. … [F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims."
- Patients "rarely won damages at trial, prevailing in only 21 percent of verdicts as compared with 61 percent of claims resolved out of court."

The authors also determined that the costs of the current system were high – but compared to what? Medical malpractice cases represent a tiny fraction of cases that pass through the civil courts every day. Health Courts contemplate establishing an entirely new administrative bureaucracy to accomplish the same thing. Insurers will still fight claims. Independent witnesses for both sides will still be needed. The Health Court process would hardly save money - unless it was done on the backs of injured patients who would be less likely to obtain adequate compensation under this system.

The second article from the May 11, 2006, *New England Journal of Medicine* argued that litigation against hospitals improves the quality of care for patients.[3] The article also confirmed that removing the threat of litigation would do nothing to improve the reporting of errors since fear of litigation is not the main reason doctors do not report errors. Highlights of this article include:

- "In the absence of a comprehensive social insurance system, the patient's right to safety can be enforced only by a legal claim against the hospital. … [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously."
- "The major safety-related reasons for which hospitals have been successfully sued are inadequate nursing staff and inadequate facilities." For example, the Illinois Supreme Court found that a hospital was at fault for failing to provide enough qualified nurses "to monitor a patient, whose leg had to be amputated because his cast had been put on too tight."
- Anesthesiologists were motivated by litigation to improve patient safety. As a result, twenty-five years ago, this profession implemented "a program to make anesthesia safer for patients" and as a result, "the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000."
- Only one quarter of doctors disclosed errors to their patients, but "the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance" [i.e., no litigation against doctors] for decades. In other words, "There are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges."
- "[B]y working with patients (and their lawyers) to establish a patient's right to safety, and by proposing and supporting patient-safety initiatives, physicians can help pressure hospitals to change their operating systems to provide a safer environment for the benefit of all patients."

Finally, statistics suggest that few who are injured by medical negligence actually file a claim, go to court, or receive any compensation for their injuries.[4] Proponents of Health Courts call this a litigation crisis that can be resolved with alternative systems. This is absurd.

First, patients who are injured by medical malpractice usually do not know that negligence was involved in the first place, or even suspect it. Hospital records certainly do not indicate errors. This situation would be no different if patients were forced to litigate in Health Courts. Certainly, the hardball litigation tactics of insurance companies that deny and fight legitimate claims will not suddenly stop either. Second, sometimes it is only after an attorney agrees to take a case, goes through the laborious process of obtaining hospital records, and has their own experts evaluate the information, that negligence can be proven. This process would be no different with Health Courts, but would be even more difficult for the patients because there would be no judge or jury to ensure a fair process. In fact, bias in the process may make it less likely that an attorney will financially risk taking the case at all.

Finally, there are many reasons why malpractice victims do not sue even when they know negligence was involved. My own father's cancer was misdiagnosed by his family physician. No one in my family even considered the notion of suing this doctor, and would not have done so no matter what kind of process was available to us. These kinds of stories are repeated every day in this country. But when a child is catastrophically injured or the breadwinner of a young family is rendered quadriplegic, families need and deserve the kind of compensation that a judge or jury, who listen to the evidence in each individual case, decide is best. While presented

ostensibly for the benefit of victims, Health Court proposals show nothing but misguided concern for what is best for patients and, particularly, the most severely injured patients.

MODELS

Sorry Works

Several alternative compensation proposals for medical malpractice cases have been discussed over the last year. The Medical Error Disclosure and Compensation (MEDiC) Program, also known as "Sorry Works", is problematic. Under the current federal proposal, "health care providers would report patient injuries to a designated officer who would determine whether those injuries resulted from a medical error. In the event that a medical error occurred, providers would explain the incident to patients, offer an apology and enter into compensation negotiations. The apologies would remain confidential, and patients could not use them as an admission of guilt in legal proceedings."[5]

There are several concerns. First, the civil justice system is structured to neutralize resource and power imbalances between the parties. Without it, negotiations become heavily tilted in favor of the doctor or hospital. There is little doubt that an uninformed patient, particularly one who is catastrophically injured, will be pressured by insurers to resolve their case for a fraction of what they need or deserve, particularly when it comes to future medical expenses. Because there is no requirement that the patient be represented by counsel, these negotiations will be extremely perilous for the injured patient. If the dispute goes to mediation, this can also be dangerous for the injured patient. Mediation can make a dispute appear as a conflict between equals that should be worked out on amicable terms for both, inducing the feeling on the injured victim's part that he or she should compromise, regardless of the justice of his or her claim.

Another problems is that, while there is the right to proceed to the judicial system if no agreement is reached after six months, the bill does not toll the statute of limitations during the negotiation period, which is a serious problem in states that have only a 1 year statute of limitations. Finally, it hardly needs to be said that keeping an admission of wrongdoing out of court is not only unfair to patients who have been hurt, but increases transaction costs as patients are forced to build their case from scratch. The real problem is the insurance company that fights patients in these cases, rather than acknowledge the culpability of the health care provider that they insure.

Health Courts

The Health Court model has generated a good deal of interest and is being strongly pushed by Common Good. The proposal that is taking shape has the following key features: specialized judges with an expertise in health care; experts hired by the Health Court; a modified form of negligence (termed "avoidability"); a compensation schedule; no juries; and no access to civil court review.

As for the standard of liability, the Health Court proposal being discussed most recently relies on a new standard entitled "avoidability." This is not a "no-fault" standard but rather contemplates some element of fault, or a judgment that care was somehow sub-optimal and this lower level of care resulted in injury.

Avoidability appears to draw from a standard applied in Sweden and lies somewhere between negligence and strict liability. It should be noted that Sweden, which is often cited as the model for current Health Court proposals, allows for tort remedies to co-exist alongside Health Courts. Moreover, Sweden has an array of other public benefits that offset costs of injuries regardless of any claims. In the U.S., however, where there are very few public benefits, the proponents of Health Courts are adamant about the exclusivity of Health Courts and the removal of all access to the court system. This can only result in injured people having to shoulder much more of the cost of the injury, without any accountability mechanisms being placed on the health care industry.

REMOVING THE JURY

Proponents of Health Courts waive away constitutional problems raised by eliminating the right to trial by the jury by citing to worker's compensation, vaccine injury compensation, tax courts, and even the National Labor Relations Board. Although each of these programs was built on a different authorizing structure, they all share an adjudication function without the aid of juries. They are also all distinguishable from Health Courts. The compensation schemes are all based on no-fault models, and the remaining alternative schemes adjudicate public, federally-created rights, not private long-standing state common law rights.

In fact, almost every state constitution guarantees the right to trial by jury in civil cases and the right to access the court system for redress. Health Courts require that patients give up these rights without any reasonable substitute. A majority of states will likely find health "courts" unconstitutional based on their state constitutional provisions safeguarding the right to a jury, the right to open access to the courts and/or the right to due process.[6]

Moreover, the determination of fault under common law is the quintessential jury function, and empirical studies support the view that a jury's ability to handle complex litigation, including medical malpractice cases, is not a problem, and has never been a problem."[7] Juries, through the group processes of collaboration and deliberation, are particularly well-suited for complex cases.[8] Jury verdicts are consistent with those of other decision-makers. A doctor-led research group examined 8,231 closed malpractice cases in New Jersey and found that the verdicts rendered by juries in the few cases that went to trial correlated with the judgment of the insurers' reviewing physicians."[9] Another analysis of various studies found: "Researchers have repeatedly found that juries and judges reach extremely similar conclusions about tort liability."[10] "Other researchers found that the evidence on judge-jury concordance in complex cases is very favorable. In one study of malpractice trials, for example, juries were harder on plaintiffs than judges were."[11]

Moreover, judges, who see how juries function every day, have enormous confidence in the jury system, including their ability to handle complex cases. In March 2000, the *Dallas Morning News* and Southern Methodist School of Law sent questionnaires to every federal trial judge in the United States, its territories and protectorates – over 900 judges. About 65 percent (594) of the federal judges responded.[12] The paper reported, "The judges' responses reflect a high level of day-to-day confidence in the jury system. Only 1 percent of the judges who responded gave the jury system low marks…. Ninety-one percent believe the system is in good condition needing, at best, only minor work… Overwhelmingly…judges said they have great faith in juries to solve complicated issues…. Ninety-six percent said they agree with jury verdicts most or all of the time. And nine of 10 judges responding said jurors show considerable understanding of legal and evidentiary issues involved in the cases they hear."[13]

STACKING THE PROCESS AGAINST THE PATIENT

Proponents of alternatives like Health Courts often make vague promises that an alternative system will be fairer to plaintiffs and/or will provide more compensation accompany such proposals. They point to benefits such as "free legal representation," "efficiency," and "quicker resolution," as reasonably just substitutes for a plaintiff's right to open access of the courts and right to trial by jury.[14]

At the outset, it is worth noting that there is no free legal representation being offered as part of the Health Courts model or any of the alternative systems. An attorney is not mandatory, but neither is this true for our civil justice system. But clearly, victims feel that they fare better with an attorney representing them and it is safe to assume the same will be true for the Health Courts, if not even more so as the administrative tribunal will have less procedural safeguards in place to assure fairness. Although it is true that a plaintiff may be given access to free "experts," these are experts picked by a panel heavily weighted toward industry.

Moreover, claims of efficiency and speed of process are belied by almost every other alternative compensation system, each of which is plagued with a host of bureaucratic, cost and political capture problems. For example:

The Vaccine Injury Compensation Program (VIC)

VIC was created by federal statute, the National Childhood Vaccine Injury Act of 1986, and went into effect on October 1, 1988.[15] Unlike Health Courts, it is based on a no-fault compensation system although many argue that the Program has been co-opted by political forces and turned into a victim's nightmare.[16] Critics contend that the process is heavily weighted against the injured parties, the process takes too long, and the HHS Secretary has removed too many injuries from the table.[17]

Agency determinations to remove certain injuries from the covered table, and limit the statute of limitations have foreclosed many claims.[18] These determinations usually cannot be reviewed or appealed. Once a claim or injury is removed from the table, the element of no-fault is also removed. The claimant is then left with the frustrating task of litigating fault in an administrative

setting without the full procedural safeguards of civil courts to guide the litigation. Personal anecdotes of those who have attempted to utilize the system describe waits of more than ten years and an increasingly adversarial nature to the "no-fault" proceedings.[19] Even with the morphing of the Program into an increasingly fault-based standard, the Vaccine Program still contemplates a no-fault arena for certain injuries. The Program's slow political capture and subsequent demise as an adequate alternative for victims should, if anything, serve as a loud warning as to the vulnerability of a fault-based alternative tribunal to address injured medical consumers.

Workers Compensation

State legislatures have been chipping away at worker's compensation systems at an alarming rate almost since its inception, in direct response to the requests of insurance carriers and businesses.[20] In many states, the process workers must go through to make claims and receive compensation has become longer, less efficient, and ultimately less successful in terms of its original goals.[21] According to one legal scholar who studies workers compensation, "injured workers often face denials and delays of apparently legitimate claims, high litigation costs, discrimination, and harassment by employers and coworkers.… [M]any reports suggest that recent reforms have substantially increased injured workers' financial burdens."[22]

It is clear that workers who are permanently disabled are not getting enough compensation and the compensation duration is too short. Data consistently shows that a worker injured at the workplace earns significantly less than before the injury, even after returning to work. For example, according to one Rand Institute for Civil Justice study, "permanent partial disability claimants injured in 1991-1992 [in California] received approximately 40 percent less in earnings over the four to five years following their injuries than did their uninjured counterparts."[23] Moreover, "for workers with minor disabilities, benefits replace a small fraction of lost wages."[24] An earlier Rand ICJ report, released in 1991 found that "injured workers recovered a lower percentage of their accident costs than all accident victims (54.1%), and that workers' compensation only compensated about 30% of the costs of long-term disabilities from work accidents."[25]

Virginia's Birth-Related Neurological Injury Compensation Program

The *Richmond Post-Dispatch* newspaper reported on this program several years ago, finding, "Children born in Virginia with catastrophic neurological injuries are promised lifetime medical care by the birth-injury program. But these children and their families also have been forced to absorb stunning disparities in program benefits because of shifting priorities and cost reductions over which they had no control or voice…. 'The program can end up providing very little,' said Christina Rigney, referring to the minimal benefits her family received in the face of her son's traumatic birth and brief life. 'We believed there was negligence involved, but nothing ever came of it.'" Her son died three years after he was severely injured due to oxygen loss during birth. Because of the birth injury law, the family couldn't file a malpractice suit, the obstetrician was never even asked to explain what happened, and the family could learn nothing from illegible notes that failed to account for long periods of time. Families of two other brain-injured infants delivered by the same obstetrician faced the same limits on their ability to learn what

happened, or seek to show he was negligent. He is facing a lawsuit, however, for a fourth case in which a woman giving birth bled to death after delivering a healthy baby.[26] National birth-injury experts have reportedly expressed fear about Virginia becoming a safe harbor for bad doctors due to this law.[27]

SECRECY ABOUT ERRORS AND INJURIES WILL CONTINUE UNDER THESE PROPOSALS

It is misguided to think that fear of litigation is the only, or even principal, reason that doctors and hospitals do not report errors. As noted in the May 11, 2006 *New England Journal of Medicine* article, "There are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges."[28]

Massachusetts may provide the best example in the country of this. Massachusetts hospitals have some of the strongest protections from liability in the nation, since nearly all fall under the state's charitable immunity laws that cap their liability at $20,000.[29] Yet, even though they run little risk of liability for errors, "statistics suggest, and leading experts confirm, that doctors and hospitals around Boston — widely considered the medical capital of the world — are vastly underreporting their mistakes to regulators and the public."[30] According to a February 2003 *Boston Magazine* article:

> In 2001, Massachusetts hospitals reported 982 serious incidents, or medical errors, to state regulators, up from 636 five years earlier, but still an average of just three reports per day. In New York State, by comparison, hospitals submitted nearly 30,000 reports, or 82 per day. In fairness, that disparity is mostly due to the different ways the states define a medical error: New York studies every little complication; Massachusetts, only major incidents. Still even New York is criticized for disclosing fewer medical errors than actually occur, and with a population only three times that of Massachusetts, it is reporting more than 30 times as many. One doctor who was a member of a Massachusetts oversight committee says statistics show there should be 10 reports of medical errors per 100 hospital beds each year. In fact, hospitals in this state are disclosing roughly three. Even when they are reported, one Harvard School of Public Health professor says, many medical errors are barely investigated because of a lack of resources.[31]

Under the birth-injury program in place in Virginia, obstetricians are not asked to explain what happened, and the family may never learn anything about what caused a catastrophic injury. According to news reports, not a single case in the program's 15-year history has produced a disciplinary action against a hospital or doctor, even though those cases "pose a high risk for findings of negligence against doctors, nurses and hospitals."[32] One mother of a daughter with cerebral palsy and other severe disabilities testified before the Virginia House that the program "has evolved from a model of care for severely disabled children to . . . safe haven for physicians and hospitals who, in some cases, are directly responsible for these catastrophic injuries."[33]

THE IMPORTANCE OF LITIGATION FOR PATIENT SAFETY

As stated earlier, the May 11, 2006, *New England Journal of Medicine* article argued that litigation against hospitals improves the quality of care for patients.[34] In a March 5, 1995, *New York Times* article, Dr. Wayne Cohen, then-medical director of Bronx Municipal Hospital, said, "The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing."[35]

Patients have suffered tremendously as a result of dangerous or incompetent health care providers, hospitals, HMOs, and nursing homes. Many unsafe practices were made safer only after lawsuits were filed against those responsible. In other words, lawsuits protect us all, whether or not we ever go to court. Moreover, the amount of money saved as a direct result of this litigation — injuries prevented, health care costs not expended, wages not lost, etc. — is incalculable. Some examples of these cases include:

- **Failure to properly monitor patient.**

FACTS: Marilyn Hathaway suffered brain damage after an anesthesiologist failed to monitor her cardiopulmonary status during surgery. In 1983, Hathaway sued the physician. The jury verdict was for $5 million in damages.[36]

EFFECT: According to the book *Silent Violence, Silent Death*, "After having to pay repeated medical malpractice claims arising from faulty anesthesia practices ... Arizona's malpractice insurance companies took action. For example, the Mutual Insurance Company of Arizona, which insures over 75 percent of the state's physicians, began levying a $25,000 surcharge on insurance premiums for anesthesiologists against whom claims had been made because constant monitoring of the patient was not performed during general anesthesia. As a result of litigation, adequate anesthesia monitoring during surgery has become a standard medical practice in Arizona."[37]

- **Tube misinsertion caused death.**

FACTS: Rebecca Perryman was admitted to Georgia's DeKalb Medical Center after suffering from kidney failure. While undergoing dialysis, a catheter inserted in her chest punctured a vein, causing her chest cavity to fill with blood. Perryman suffered massive brain damage and lapsed into a coma. She died two weeks later. Perryman's husband Henry filed suit against DeKalb and its Radiology Group, as well as the doctor who failed not only to spot the misplaced catheter in Perryman's chest x-ray but also to quickly respond to the victim's excessive bleeding. DeKalb and the Radiology Group settled before trial for an undisclosed amount; a jury awarded $585,000 against the doctor.[38]

EFFECT: "After the award, the radiology department instituted new protocol for verifying proper placement of catheters." [39]

- **Emergency room failed to diagnose heart disorders.**

FACTS: Three Air Force servicemen died after being discharged from the emergency room without proper examination. Though each had a history of heart problems and displayed classic symptoms of heart disorder, all three were misdiagnosed with indigestion.[40]

EFFECT: "As a result of malpractice litigation, the Air Force investigated the deaths and instituted stringent new requirements for diagnostic testing ... These procedures are now standard practice at Air Force medical facilities throughout the world."[41]

- **Newborns left in nursery without supervision.**

FACTS: In September 1982, James Talley was born at Doctors Hospital in Little Rock, Arkansas. He was left alone for 35 minutes, 10 to 15 of which he stopped breathing. When a nurse came to check on him, his heart had stopped and he had turned blue. The oxygen deprivation caused permanent brain damage. The Talleys sued Hospital Corporation of America (HCA), Doctors Hospital's parent company, arguing that HCA's cost cutting procedure of reducing the number of nurses in the pediatric unit placed newborns at risk of injury or death. At trial, evidence showed that it would have cost Doctors Hospital an additional $70,000 per year per nurse to have someone in the nursery at all times and that the hospital was consistently two nurses short on the nightshift. The jury awarded $1.85 million in compensatory damages for James, $777,000 to his mother and $2 million in punitive damages.[42]

EFFECT: "As a result of this decision, HCA changed its policy on staffing pediatric units throughout its chain of hospitals, potentially saving hundreds of new lives and preventing as many injuries."[43]

- **Staffing problem endangered patients.**

FACTS: On January 26, 1998, Dr. Roberto C. Perez suffered severe brain damage after a nurse, who had been working over 70 hours a week and was just finishing an 18-hour shift, injected him with the wrong drug. Perez had been admitted to Mercy Hospital in Laredo, Texas, two weeks earlier after a fainting spell and was almost ready to be discharged. His family filed a medical malpractice suit against Mercy Hospital, among others, arguing that hospital administrators knew since 1994 that staffing problems existed yet failed to do anything about the nursing short-age. The case settled before trial, with the hospital paying $14 million.[44]

EFFECT: As part of the settlement, Mercy Hospital agreed that no nurse in the ICU would be allowed to work more than 60 hours per week.[45]

- **Bacterial infection spread to hospital roommate.**

FACTS: In 1983, 72-year-old Julius Barowski contracted a bacterial infection from a fellow patient after undergoing knee replacement surgery. His condition required 11 hospitalizations and 9 surgeries; his leg lost all mobility. As the infection spread, he suffered excruciating pain and was institutionalized for depression until his death one year later. Barowski's representative filed suit, alleging that the hospital breached its own infection control standards. The jury awarded $500,000.[46]

EFFECT: "The Widmann ruling and similar cases have had a catalytic impact in health care facilities around the country. Facilities are much more attentive to the clinical importance of cleanliness in all its dimensions — handwashing, routine monitoring of infection risks, and more vigorous reviews of hospital infection control protocols." [47]

- **Inadequate monitoring led to patient's death.**

FACTS: In 1996, 78-year-old Margaret Hutcheson lapsed into a coma and died after a two-and-a-half month stay at Chisolm Trail Living & Rehabilitation Center. Hutcheson had been admitted to Chisolm for short-term rehabilitation after fracturing her hip and wrist at home. While residing at the center, she suffered severe pressure sores, malnourishment and dehydration, which required three hospitalizations. Hutcheson's family sued the facility and its personnel for wrongful death, arguing that Chisolm was understaffed and failed to follow internal procedures to ensure Hutcheson's safety. The jury awarded $25 million.[48]

EFFECT: As part of the settlement, Diversicare, the nursing home operator, "agreed to adopt a policy requiring the residents' charts be monitored on a weekly basis to ensure their needs are being met. This policy has been implemented in all 65 nursing homes owned or operated by Diversicare, and will benefit over 7,000 nursing home residents."[49]

- **Nurses feared consequences of challenging doctors' actions.**

FACTS: On April 30, 1979, Jennifer Campbell suffered permanent brain damage after becoming entangled in her mother's umbilical cord before delivery. Although a nurse had expressed concern when she noticed abnormalities on the fetal monitor, the obstetrician failed to act. Despite the doctor's unresponsiveness, the nurse never notified her supervisor or anyone else in her administrative chain of command. The child developed cerebral palsy, requiring constant care and supervision. Evidence revealed that the hospital lacked an effective mechanism for the nursing staff to report negligent or dangerous treatment of a patient. In addition, the nursing supervisor testified that an employee could be fired for questioning a physician's judgment. The jury awarded the Campbells over $6.5 million.[50]

EFFECT: "Because of this verdict and its subsequent publicity, hospitals throughout North Carolina have adopted a new protocol that allows nurses to use their specialized training and judgment on behalf of patients, without risking their jobs." [51]

- **Patient prescribed incorrect chemotherapy dosage.**

FACTS: When 41-year-old Vincent Gargano was diagnosed with testicular cancer in 1994, he was given a 90 percent to 95 percent chance of survival. On May 26, 1995, he entered the University of Chicago Hospitals to undergo his last phase of chemotherapy. For four consecutive days Gargano received a dosage that was four times the needed amount, a mistake that went undetected by at least one doctor, two pharmacists and four nurses until four overdoses had already been administered. Hospital records showed that the prescribing doctor wrote the incorrect dosage and that three registered nurses failed to double-check the prescription against the doctor's original order. As a result, Gargano suffered hearing loss, severe kidney damage, festering sores and ultimately the pneumonia that caused his death the following month. The case settled for $7.9 million.[52]

EFFECT: The hospital implemented new policies to ensure that doctors and nurses better document and cross-check medication orders.[53]

SOME SOLUTIONS TO REDUCE MEDICAL ERRORS

There is no doubt that deaths and injuries due to medical malpractice are substantial. In late 1999, the National Academy of Sciences Institute of Medicine (IOM) published *To Err is Human; Building a Safer Health System.* The study makes some striking findings about the poor safety record of U.S. hospitals due to medical errors.[54] For example, between 44,000 and 98,000 deaths occur each year in U.S. hospitals due to medical errors, the higher figure extrapolated from the 1990 Harvard Medical Practice study of New York hospitals. Even using the lower figure, more people die due to medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).

A recent survey found, "[e]ighty percent of U.S. doctors and half of nurses surveyed said they had seen colleagues make mistakes, but only 10 percent ever spoke up." Moreover, "fifty percent of nurses said they have colleagues who appear incompetent" and "[e]ighty-four percent of physicians and 62 percent of nurses and other clinical care providers have seen co-workers taking shortcuts that could be dangerous to patients." Doctors and nurses do not talk about these problems because "people fear confrontation, lack time or feel it is not their job."[55]

There is much that can and should be done. Unfortunately, too little is being done to weed out the small number of doctors responsible for most malpractice. As the *New York Times* reported,

> Experts retained by the Bush administration said on Tuesday that more effective disciplining of incompetent doctors could significantly alleviate the problem of medical malpractice litigation.

> As President Bush prepared to head to Illinois on Wednesday to campaign for limits on malpractice lawsuits, the experts said that states should first identify those doctors most likely to make mistakes that injure patients and lead to lawsuits.
>
> The administration recently commissioned a study by the University of Iowa and the Urban Institute to help state boards of medical examiners in disciplining doctors.
>
> "There's a need to protect the public from substandard performance by physicians," said Josephine Gittler, a law professor at Iowa who supervised part of the study. "If you had more aggressive policing of incompetent physicians and more effective disciplining of doctors who engage in substandard practice, that could decrease the type of negligence that leads to malpractice suits.'"
>
> Randall R. Bovbjerg, a researcher at the Urban Institute, said, "If you take the worst performers out of practice, that will have an impact" on malpractice litigation.[56]

Public Citizen's Health Research Group has made similar findings for many years.[57] The group found that only one-half of 1 percent of 770,320 licensed medical doctors face any serious state sanctions each year. "Too little discipline is still being done," the report said. "2,696 total serious disciplinary actions a year, the number state medical boards took in 1999, is a pittance compared to the volume of injury and death of patients caused by negligence of doctors…. Though it has improved during the past 15 years, the nation's system for protecting the public from medical incompetence and malfeasance is still far from adequate."

Other problems that can be addressed include:

Safer RN staffing ratios. A 2002 study in the Journal of the American Medical Association found that patients on surgical units with patient-to-nurse ratios of 8:1 were 30 percent more likely to die than those on surgical units with 4:1 ratios.[58]

Reduce continuous work schedules. According to studies published in the October 28, 2004, issue of the *New England Journal of Medicine*, "The rate of serious medical errors committed by first-year doctors in training in two intensive care units (ICUs) at a Boston hospital fell significantly when traditional 30-hour-in-a-row extended work shifts were eliminated and when interns' continuous work schedule was limited to 16 hours, according to two complementary studies funded by the National Institute for Occupational Safety and Health (NIOSH) and the Agency for Healthcare Research (AHRQ). Interns made 36 percent more serious medical errors, including five times as many serious diagnostic errors, on the traditional schedule than on an intervention schedule that limited scheduled work shifts to 16 hours and reduced scheduled weekly work from approximately 80 hours to 63. The rate of serious medication errors was 21 percent greater on the traditional schedule than on the new schedule.[59]

Better technology in hospitals to provide better care with greater consistency. A handful of hospitals are starting to use technology to make prenatal care and delivery safer. These hospitals are using computer software that improves monitoring and treatment.[60]

CONCLUSION

Under Health Courts, the long-standing and fundamental right to trial by jury is eliminated for medical malpractice victims. Instead, patients are forced into an alternative system without juries, without any accountability mechanisms, without procedural safeguards, and without any meaningful appeals process. These hardships, coupled with the burden of having to prove fault, render the injured claimant virtually powerless and at the mercy of the insurance and hospital industries.

Safety suffers when systems are not designed to reflect the full costs of accidents. Our objectives should be deterring unsafe and substandard medical practices while safeguarding patients' rights. Indeed, our goal must be to reduce medical negligence. This is not the time to establish a new process, which will only protect incompetent doctors even more from meaningful liability exposure and scrutiny, including the most egregiously reckless health care providers.

NOTES

[1] David M. Studdert, Michelle Mello, et al. "Claims, Errors, and Compensation Payments in Medical Malpractice Litigation," *New England Journal of Medicine,* May 11, 2006.
[2] *Ibid*.
[3] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.
[4] Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York,* 1990.
[5] "Medical Errors: Rodham Clinton, Obama Propose Disclosure; Program, *American Health Line*," September 29, 2005.
[6] See, Amy Widman, Center for Justice & Democracy, "Why Health Courts are Unconstitutional" (publication forthcoming by the Pace Law Review), http://centerjd.org/press/opinions/HealthCourtsUnconstitutional.pdf.
[7] Philip G. Peters, Jr. "The Role of the Jury in Modern Malpractice Law," 87 *Iowa L. Rev.* 909, 927-28 (2002), http://papers.ssrn.com/sol3/Papers.cfm?abstract_id=310681.
[8] *Ibid.*
[9] Marc Galanter, "Real World Torts: An Antidote to Anecdote," 55 *Maryland L. Rev.* 1093, 1111 (1996), *citing* Mark I. Taragin et al., "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," 117 *Annals Internal Med.* 780, 782, 780 (1992).
[10] Philip G. Peters, Jr. "The Role of the Jury in Modern Malpractice Law," 87 *Iowa L. Rev.* 909, 922 (2002), http://papers.ssrn.com/sol3/Papers.cfm?abstract_id=310681.
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[12] Allen Pusey, "Judges Rule in Favor of Juries: Surveys by Morning News, SMU Law School Find Overwhelming Support for Citizens' Role in Court System," *Dallas Morning News*, May 7, 2000.
[13] *Ibid*.
[14] See Kirk B. Johnson, "*A Fault-Based Administrative Alternative for Resolving Medical Malpractice Claims*," 42 VAND. L. REV. 1365, 1401 (1989).
[15] National Childhood Vaccine Injury Act of 1986, P.L. 99-660.
[16] Id.; see also Statement of the National Vaccine Information Center Co-Founder & President Barbara Loe Fisher, September 28, 1999, House Oversight Hearing, "*Compensating Vaccine Injury: Are Reforms Needed?*" (discussing the unilateral power DHHS has to change the burdens of proof and other restrictions); Derry Ridgway, "*No-Fault*

Vaccine Insurance: Lessons from the National Vaccine Injury Compensation Program," 24 J. HEALTH POL'Y & L. 59, 69 (1999)("Lessons")(describing how the program originally awarded many more claims, until the Department of Justice decided to aggressively argue against claimants.)

[17] See Elizabeth C. Scott, "*The National Childhood Vaccine Injury Act Turns Fifteen*," 56 FOOD & DRUG L.J. 351 (2001)(stating that, as of 2001, 75 percent of claims were denied after long and contentious legal battles taking an average of 7 years to resolve).

[18] See, e.g., Lessons, supra note 38, at 86.

[19] See Elizabeth C. Scott, "*The National Childhood Vaccine Injury Act Turns Fifteen*," 56 FOOD & DRUG L.J. 351, 358-363 (2001)(discussing "horror stories about the length of time it takes them to process the case and receive compensation . . . [and] families who've gone bankrupt trying to meet their children's medical and emotional needs while going through the system." Also noting the adversarial nature of these "combative mini-trials," where, even after the decision to compensate is made, veteran DOJ litigators "fight over minutia like the future cost of diapers in a certain state.")

[20] See "Worker's Comp: Falling Down on the Job," Consumer Reports, 2000 (discussing the legislative reforms of the 1990s and the resulting profits for worker's compensation insurance providers).

[21] See Hammond and Kniesner, "The Law and Economics of Worker's Compensation," Rand Institute for Civil Justice, 1980.

[22] McCluskey, Martha T., "The Illusion of Efficiency in Workers' Compensation "Reform," 50 Rutgers L. Rev 657, 699-700, 711 (1998) n. 158, 159, 160

[23] See, Rand Research Brief, "Compensating Permanent Workplace Injuries," 1998.

[24] Id.

[25]McCluskey, Martha T., "The Illusion of Efficiency in Workers' Compensation "Reform," 50 Rutgers L. Rev 657, 699 (1998) n. 156, 157 (citing Deborah R. Hensler et Al., *Compensation For Accidental Injuries In The United States* 107 fig.4.8 (1991)).

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[28] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

[29] Mass. Gen. Laws ch. 231, § 85K (2003).

[30] Doug Most, "The Silent Treatment," *Boston Magazine*, Feb. 2003.

[31] *Ibid.*

[32] Bill McKelway, "Brain Injuries Spur No Action; Case Review, Required by Law, Is Not Being Done, Va. Study Found," *Richmond Times Dispatch*, Jan. 14, 2003.

[33] Bill McKelway, "Panel Approves Bill on Birth Injuries; Would Expand Benefits and Notification Rights," *Richmond Times Dispatch*, Jan. 29, 2003.

[34] George J. Annas, J.D., M.P.H., "The Patient's Right to Safety – Improving the Quality of Care through Litigation against Hospitals," *New England Journal of Medicine*, May 11, 2006.

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[36] *Frank v. Superior Court of the State of Arizona et al.,* 150 Ariz. 228 (1986).

[37] Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), p. 56, citing Holzer, James F., "The Advent of Clinical Standards for Professional Liability," *Quality Review Bulletin*, Vol. 16, No. 2 (February 1990).

[38] *Perryman v. Rosenbaum et al.*, No. 86-3453 (DeKalb County Super. Ct., Ga., verdict June 5, 1991).

[39] Koenig, Thomas & Michael Rustad, *In Defense Of Tort Law*. New York: New York University Press (2001), citing letter correspondence from W. Fred Orr, III, Henry Perryman's attorney, dated April 26, 1994.

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[41] Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), p. 57, citing telephone interview with C. Wes Pittman, one of the servicemen's attorneys.

[42] "Saving The Newborn," *Trial Lawyers Doing Public Justice* (July 1987), citing *National Bank of Commerce v. HCA Health Services of Midwest, Inc.*, No. 84-160 (Saline County Cir. Ct., Ark., verdict October 6, 1986). *See also*, Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), pp. 578.
[43] "Saving The Newborn," *Trial Lawyers Doing Public Justice* (July 1987).
[44] *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., settlement October 28, 1999); *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., fourth amended original petition, filed October 22, 1999)(on file with CJ&D).
[45] *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Webb County Ct., Tex., settlement October 28, 1999); *Perez v. Mercy Hospital*, No. 98 CVQ 492-D3 (341st Judicial Dist., Webb County Ct., Tex., release and settlement agreement, October 28, 1999)(on file with CJ&D).
[46] *Widmann v. Paoli Memorial Hospital*, No. 85-1034 (E.D. Pa., verdict December 9, 1988). *See also*, Rosenfeld, Harvey, *Silent Violence, Silent Death*. Washington, DC: Essential Books (1994), pp. 556.
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[48] *Olson et al. v. Chisolm Trail Living & Rehabilitation Center et al.*, No. 98-0363 (Caldwell County Ct., Tex., verdict August 26, 1999). *See also*, Osborn, Claire, "Family of care center resident who died awarded $25 million," *Austin AmericanStatesman*, August 27, 1999.
[49] *Texas Reporter Soele's Trial Report* (November 1999). *See also*, Malone, Julia, "Lawyers Filling Gap Left By Regulators," *Palm Beach Post*, September 25, 2000.
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[57] *See, e.g.,* Sidney Wolfe et al., *20,125 Questionable Doctors*, Public Citizen Health Research Group, Washington, DC (2000).
[58] L.H. Aiken et al., "Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction," 288 JAMA 1987 (Oct. 23/30, 2002).
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